Twin Falls Mutual Insurance Company in Liquidation
Fourth District Ada County Case No. CV OC 05-01668

Proof of Claim - ALL CLAIMS MUST BE RECEIVED BY THE LIQUIDATOR NO LATER THAN 5:00 PM AUGUST 1, 2005

1. Identity of Claimant:
   Name_____

   Address_____

   City_____ State_____Zip_____

   Telephone_____FAX_____

   Social Security No. or Tax ID: _____ (Not required for Policyholder Claims)

   Claimant's Email address:_____
   (NOTE: by giving email address, the claimant agrees to receive notices electronically)

2. The claim is based upon (check one)
   (a)_____an insurance policy:
   Policyowner Name:_____
   Policy No:_____
   Agent:_____

   (b)_____ _a basis other than an insurance policy. (If claim is not based on a policy of insurance, then please submit a Form W-9 (http://www.irs.gov/pub/irs-pdf/fw9.pdf or available from the Liquidator) with your Proof of Claim.)

3. Total amount of claim $_____ (dollar amount of claim).

4. Describe the nature of the claim, including the money or other consideration paid (claims include general creditor claims as well as insurance policy claims):
   _____
   _____
   _____
   _____

5. The date of loss if a policyholder claim, or the date the claim otherwise arose if a general or other creditor:_____

6. The identity and amount of the security or collateral securing the claim, if any, (please attach a copy of any document that demonstrates the security interest):
   _____
   _____

7. List all payments already made, if any, to or on behalf of the claimant against the debt or amount claimed. Include the amount and date of payment(s).
   _____

8. In making this Proof of Claim, I hereby certify that the sum claimed is justly owed and there is no set off, counterclaim, or defense to the claim.

9. Describe any asserted right of priority (*see e.g.* Idaho Code section 41-3342) to payment or other specific right and describe the specific reasons such priority or right is asserted: _____
_____

10. This claim is based upon a written instrument (other than an insurance policy) which is described as follows (date, general description, and the parties to the written instrument), and attach a copy of the instrument: _____
_____

11. I am represented by the following attorney(s):

Name of attorney:_____

Address:_____

City:_____ _____State:_____ Zip:_____

Telephone No.:_____ Email:_____

I understand that the Liquidator may deny this claim if it does not contain all of the information applicable for my claim. I further understand that the Liquidator may request that I provide additional information or evidence supplementary to that required in this claim form and may take testimony under oath, require production of affidavits or depositions or otherwise obtain additional information or evidence. If any information in this Proof of Claim has changed or is later determined to be inaccurate, the claimant shall file an amended Proof of Claim Form. State law (Idaho Code § 41-293) provides criminal penalties for anyone making a knowingly false statement to an insurer with the intent to deceive or defraud.

Check here if this is an amended Proof of Claim Form: _____

I, _____, state that I am the claimant in the above entitled Proof of Claim; that I have read said Proof of Claim, know the contents thereof, and that the same is true and correct as I verily believe. Dated this _____ day of _____, 2005.

_____
Claimant signature

_____
Claimant name printed

This form and any attachments must be received by the Liquidator no later than 5:00 p.m. August 1, 2005. Send this form and any attachments to:

Liquidator, Twin Falls Mutual Insurance Co.
Idaho Department of Insurance
700 West State Street
P.O. Box 83720
Boise, ID 83720-0043
Telephone: (208) 334-4250, or 1-800-721-3272
Fax: (208) 334-4398; twinfallsmutual@doi.idaho.gov